STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Revised report text changes made to F600 An unannounced complaint survey was conducted at this facility from January 30, 2019 through February 7, 2019. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 94. The survey sample size was 15. Abbreviations/definitions used in this report are as follows: Acute - new, sudden; ADLs - Activities of Daily Living/tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; Alzheimer's Disease - degenerative disorder that attacks the brain's nerve cells resulting in loss of memory, thinking and language; Amlodipine-Valsartan - medication that treats high blood pressure; Aspiration - inhaling fluid or food into the lungs; Aspiration Pneumonia- inflammation of lungs and bronchial tubes by inhaling foreign matter such as food or vomit which leads to bacterial infection; Aspiration precautions - practices that help prevent inhaling food or fluid into the lungs; Bumetanide - a potent diuretic (water pill) used to treat swelling caused by heart failure, liver or kidney disease causing increased urination; CAA - Care Area Assessment/part of the MDS assessment which assists in identifying and planning for potential problem care areas; CNA - Certified Nurse's Aide; Cognitively Impaired - abnormal mental processes; thinking OR mental decline including losing the ability to understand, the ability to talk	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/28/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1	F 000		

or write, resulting in the inability to live independently;
Cognitively Intact - able to make own decisions;
Continence - control of bladder and/or bowel function;
CT Scan - imaging test that takes detailed pictures of the inside of the body;
Delusions - a belief held with strong conviction despite evidence to the contrary;
Dementia - loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning;
Dysphagia - difficulty swallowing;
DON - Director of Nursing;
E.G. (e.g.)- such as;
ER - Emergency Room;
Fiberoptic Endoscopic Evaluation of Swallowing / FEES - test that allows for the assessment of swallowing disorders and the implementation of interventions with the goal of promoting safe and efficient swallowing;
Hematoma - collection of blood as a result of trauma, such as a black eye;
H&P - History and Physical;
Incontinence/incontinent - loss of control of bladder and/or bowel function;
Kardex - CNA plan of care for individual residents;
LPN - Licensed Practical Nurse;
MAR - Medication Administration Record;
MD - Medical Doctor;
MDS - Minimum Data Set/standardized assessment forms used in nursing homes;
mm - millimeter;
Modified Barium Swallow Study - procedure designed to determine whether food or liquid is entering a person's lungs, also known as aspiration;
Neuro checks - Neurological checks/assessment comprised of a series of simple questions and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 2	F 000		

physical tests to determine if the nervous system is impaired;
Neurontin - medication that treats nerve pain;
NHA - Nursing Home Administrator;
NP - Nurse Practitioner;
OT - Occupational therapy/therapist;
Overactive bladder - a bladder control problem which leads to a sudden urge to urinate;
Parameters - a limit or boundary;
Post- after;
PRN/prn - as needed;
Psychosocial - involving both psychological and social aspects;
Pubic ramus fracture - the pubic ramus is part of the pelvic bone, the front part that meets up with the pubic bone (the one that can be felt in the pelvis, lower front abdominal wall). A fracture is a broken bone;
Reflux - the return of stomach contents back up into the throat and frequently causes heartburn because of irritation of the throat by the stomach acid;
RD - Registered Dietitian;
RN - Registered Nurse;
ROM - Range of Motion - extent to which a joint can be moved safely;
SBAR - stands for Situation, Background, Assessment, Recommendation; a technique that can be used to facilitate prompt and appropriate communication between physicians and nursing;
ST - Speech Therapy/Therapist;
Subdural hematoma- a collection of blood between the brain and its outermost covering;
Subgaleal hematoma - an area of bleeding between the skull and scalp;
Supine - lying face upward;
Systolic blood pressure - the top number of the blood pressure reflects pressure in vessels when the heart is beating;
Vascular Dementia - a general term describing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 3 problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to your brain.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 550		3/6/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 4 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R14) out of 15 sampled residents, the facility failed to promote care in a manner and environment that maintained or enhanced R14's dignity and respect in full recognition of his/her individuality. Findings include: Review of R14's clinical record revealed: 11/6/18- R14's quarterly MDS assessment stated that he/she was cognitively intact. 2/1/19- An incident report stated that at 8:30 AM, E9 (CNA) was overheard yelling at R14. 2/5/19 11:35 AM- During an interview, R14 stated that he/she remembered a staff member yelling at him/her because he/she needed them to do something. R14 stated that he/she was upset by the situation and felt the staff member should not be speaking to him/her that way. 2/6/19 9:38 AM- During an interview, E7 (CNA) stated that she was there when the incident on 2/1/19 occurred between R14 and E9 (CNA). E7 (CNA) stated R14 was upset that his/her ginger ale was opened because he/she wanted to save it to drink later. E7 (CNA) stated that E9 (CNA) and R14 were both speaking at the same time about the situation, which made the conversation sound loud. E7 (CNA) stated that E9 (CNA) was trying to	F 550	Preparation and submission of this Plan of Correction does not constitute an admission of or agreement with, it is required by State and Federal law. It is executed and implemented as a means to continuously improve the quality of care to comply with State and Federal requirements. 1) E-9 was educated on dignity and respect of residents individuality. R14 was evaluated for symptoms of long and/or short term psychosocial distress. No negative findings observed. 2) All residents have the potential to be affected. These residents were interviewed to identify if staff has been providing care in a respectful and dignified environment. If identified, a facility investigation will be initiated and all attempts made to preserve that resident's right. There were no negative findings. 3) To prevent this from recurring the Director of Nursing/or delegate will educate staff on professionalism and how to recognize inappropriate conversation within the workplace. Staff will also be educated on providing care in a dignified and respectful environment. 4) To monitor and maintain ongoing compliance management team will complete off hour visits; all shift, halls including weekends 3 times weekly for 4	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 5 get her point across to R14 and was speaking loudly to R14, but was not yelling. 2/6/19 10:25 AM- During an interview, E8 (RN) stated that she reported the situation that occurred on 2/1/19 between R14 and E9 (CNA). E8 (RN) stated that she overheard the end of the conversation and E9 (CNA) was speaking loudly to R14, but was not yelling. E8 (RN) stated that she pulled E9 (CNA) out of the room and talked to her about not speaking to residents in that manner. The facility failed to promote care in a manner and environment that maintained or enhanced R14's dignity and respect in full recognition of his/her individuality when E9 (CNA) was observed speaking loudly to R14, which caused R14 to feel upset. 2/7/19 1:30 PM- Findings were reviewed with E2 (interim DON) and E3 (Risk Manager). Findings were reviewed during the exit conference on 2/7/19 at approximately 3:45 PM with E1 (NHA), E2 (acting DON), E3 (Risk Manager), and E20 (Regional Director of Clinical Services).	F 550	weeks until 100% compliance is achieved and then 1 time weekly for 2 months until substantial compliance is maintained. Management staff will also randomly interview 10 of the residents to confirm that the staff is providing care in respectful and dignified environment 3 times weekly for 4 weeks until 100% compliance is achieved and then weekly times 2 months until substantial compliance is maintained. Results to be reported to QAPI committee monthly for further review and recommendations.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical,	F 580		3/6/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 6 mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by:	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 7 Based on interviews and record review, it was determined that for one (R6) out of 15 sampled residents, the facility failed to immediately consult with the resident's physician when there was an accident involving the resident which resulted in injury and had the potential for requiring physician intervention. For R6, the facility failed to immediately consult with the physician when R6 had an unwitnessed fall with a head injury. Findings include: Cross refer to F689 Review of R6's clinical record revealed: 10/14/18- The facility's Incident/Accident Report, completed by E11 (LPN), documented that at 6:40 AM, R6 "was found on the floor next to the bathroom door ...on (sic) a supine position ...Resident was noted with a hematoma to posterior of his/her head." It was documented that the physician was notified at 8:00 AM. 10/14/18- The facility's SBAR Communication Form, completed by E11 (LPN), documented a description of the incident and stated that the physician was notified of R6's fall with a head injury at 8:00 AM. Upon notification, the physician ordered for R6 to be sent to the ER for evaluation. 10/14/18- Review of R6's hospital record revealed, R16 was found to have a 2mm subdural hematoma. The facility failed to immediately consult with the physician when R6 had an unwitnessed fall with a head injury on 10/14/18 at 6:40 AM. The facility documented that the physician was notified at 8:00 AM, which was 1 hour and 20 minutes after	F 580	Preparation and submission of this Plan of Correction does not constitute an admission of or agreement with, it is required by State and Federal law. It is executed and implemented as a means to continuously improve the quality of care to comply with State and Federal requirements. 1) Resident's physician was notified of the event at 8:00 am on 10/19/18. Neuro checks and vital signs were within normal limits. 2) All residents who have fallen have the potential to be affected. An audit of resident falls from date of survey exit was conducted to ensure timely physician notification was completed. Corrective action taken when indicated. 3) To prevent this from recurring the Director of Nursing/or delegate will educate professional staff on timely physician notification after a fall. 4) To monitor and maintain ongoing compliance DON/designee will review residents with falls for timely physician notification 4 times weekly for 4 weeks until 100% compliance is achieved then weekly for 2 months until substantial compliance is maintained. Results to be reported to QAPI committee monthly for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 8 R6 fell and sustained head trauma. 2/7/19 1:30 PM- Findings were reviewed with E2 (interim DON) and E3 (Risk Manager). Findings were reviewed during the exit conference on 2/7/19 at approximately 3:45 PM with E1 (NHA), E2 (acting DON), E3 (Risk Manager), and E20 (Regional Director of Clinical Services).	F 580		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on review of facility documentation, interviews, and clinical record review, it was determined that for 1 (R15) out of 15 sampled residents, the facility failed to ensure that the resident was free from abuse. This resulted in the facility's failure to ensure that R15 was free from verbal and physical abuse. E24 (CNA) taunted R15 to the point of anger that caused aggression resulting in a physical confrontation in which E24 pushed R15. Findings include:	F 600	Preparation and submission of this Plan of Correction does not constitute an admission of or agreement with, it is required by State and Federal law. It is executed and implemented as a means to continuously improve the quality of care to comply with State and Federal requirements. 1) E-24 was terminated from employment. R-15 was evaluated to ensure no	3/6/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 9 Review of E24's personnel record revealed the following: E24 was hired on 8/5/16 following a criminal background check and an abuse registry check. The facility provided E24 with the following training: October 2018 - E24's transcript stated that she completed training for Alzheimer's Disease and Related Disorders, Behavior Management and Handling Aggressive Behaviors. December 2018 - E24's transcript stated that she completed training for Fraud, Waste and Abuse for Management. Review of R15's clinical record revealed the following: 12/18/18 - The quarterly MDS assessment stated that R15's mental status was severely impaired. R15's mobility device was a wheelchair in which he/she was able to move about the facility independently. A care plan initiated in December 2015 and last reviewed 12/20/18, stated that R15 had potential for aggression toward staff when agitated, with an intervention of "do not corner if agitated, provide space ...speak softly." 1/1/19 -1/31/19 - Review of the Behavior monitoring sheet stated that R15 was monitored for delusions, yelling, throwing things, and sadness. The form was marked with zeros for all shifts for all days of the month, indicating that R15 was not having any of these behaviors.	F 600	long-term effects from event. No adverse effects identified. 2) All residents have the potential to be affected. All cognitively intact residents were interviewed to ensure no perceived abusive and unreported events occurred. All cognitively impaired residents received skin checks to ensure no evidence of abuse was identified. Findings were negative for incidence of suspected abuse. 3) To prevent this from recurring the Director of Nursing/or delegate will educate staff on Appropriate conversation and professional demeanor when caring for residents. The staff will also receive education on the facility abuse policy. 4) To monitor and maintain ongoing compliance the DON/ Designee will interview 10 cognitively intact residents to ensure no perceived abuse 3 times weekly for 4 weeks until 100% compliance is achieved then weekly for 2 months until substantial compliance is maintained. 3 cognitively impaired residents will receive skin checks to ensure no evidence of potential abuse 3 times weekly for 4 weeks until 100% compliance is achieved then weekly for 2 months until substantial compliance is maintained. Results to be reported to QAPI committee monthly for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 10	F 600		

1/31/19 - The facility scheduling sheet lacked evidence that E24 was scheduled to work on that date.

1/31/19 - The Revised 3-11 CNA Assignment Sheet lacked evidence that E24 (CNA) was scheduled any responsibilities, showers, or meals on that date.

1/31/19 at 10:07 PM - The facility self reported an allegation of abuse for R15 to the State Agency. The incident report stated, "Resident has a primary diagnosis of dementia. He/She was in an agitated state and was upset that all his/her children were dead. E24 (CNA) was sitting at the desk. The resident did strike at the aide and the aide stated she put her arms up in self-defense. Other staff reported that the aide (E24) struck the resident. The aide (E24) was suspended immediately. A skin check of the resident did not show any marks or injuries where he/she was struck. The police were called and came into the building to interview the staff and resident. Investigation is open."

Review of the facility's incident report and investigation revealed the following statements:

1/31/19 - A written statement completed by E12 (CNA) stated, "R15 was yelling about his/her kids being missing at the nurses station. Then R15 and E24 (CNA) were going back and forth. The nurse told E24 to stop so R15 could calm down. E24 jumped at R15 and said 'boo'. That had R15 even more upset and then R15 wheeled up to E24 and stood up and hit E24 in her arm then her face, and E24 pushed R15 back and R15 fell into E14's (RN) arms. E14 asked E24 to stop and walk away and then R15 calmed down."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 11	F 600		

1/31/19 - A written statement completed by E13 (CNA) stated, "R15 was asking me and the other aides at the desk about his/her children. E24 (CNA) started going back and forth with R15. I saw that R15 was becoming more and more agitated so I asked E24 to stop because I didn't want R15 to start throwing things, but E24 kept sticking out her tongue and jumping at R15 and that made this worse. The nurse asked her to stop and leave the nurses station, but E24 refused. R15 tried to get up out of the chair and fight E24, but the nurse E14 (RN) was trying to hold him/her. E14 asked E24 and so did I, to leave the nurses station so R15 would not see her, but she refused. R15 started to go to his/her room but instead he/she jumped up out of the chair and punched E24 a few times. E24 pushed R15 back away from her. R15 fell back into nurse's arms and we asked E24 again to leave so R15 could calm down. Finally she left the nurses station."

Undated - A written statement completed by E14 (RN) stated, "This writer was passing meds and heard R15 calling staff names. One to one intervention with R15 to encourage him/her to read a paper ...R15 did not respond to me. At that time I asked staff to leave the nursing station because R15 was trying to hit staff."

1/31/19 - A disciplinary action form was completed by E3 (Risk Manager) for E24 (CNA) for suspension pending investigation. The form listed the date and time of the violation as 1/31/19 at 7:45 PM. A description of the incident stated, "It was reported that you struck a resident. That is a violation of the abuse policy." The form was not signed by the employee.

2/1/19 - A written statement completed by E24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 12	F 600		

(CNA) stated, "Resident (R15) was at the nursing station upset and everyone was laughing. I did not take it personal. Saying he/she gonna kill himself/herself if he/she don't get his/her kids. He/She was calling me bitch and a lot of names while we all take it for a joke, I did not take it personal and the nurse ask me to get up. I did and stand at the nursing station. Then the nurse was pushing the resident to his/her room when he/she hit me and I put my hands up to prevent him/her from hitting me again. As I say I know that how the resident always behave and I always calm him/her down. I did not hit the resident or touch him/her and he/she hit me I did not take it personal because I know he/she is not in his/her right mind."

2/1/19 - A written statement completed by E3 (Risk Manager) stated that on 1/31/19 at 9:30 PM, the resident's daughter was notified of the incident.

2/5/19 at 1:40 PM - An interview with E12 (CNA) confirmed the written statement dated 1/31/19.

2/5/19 at 1:50 PM - An interview with E13 (CNA) confirmed the written statement dated 1/31/19.

2/5/19 at 4:10 PM - During an interview, E14 (RN) stated she was in the 500 hallway giving medication when she heard R15 calling the staff names and went to the nurses' station to see what was going on. E14 stated that she told E24 (CNA) to leave the area, but she didn't. E14 stated that she directed R15 to his/her room, but when R15 came alongside E24, R15 stood up and started hitting E24. E14 stated that E24 put up her arms. E14 stated that she told E24 to leave again and E24 walked down the hallway. E14 stated she then called the supervisor and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 13 DON to report the incident. 2/6/19 at 1:15 PM - During an interview, E5 (Staff Development) was asked by the surveyor why E24 (CNA) was in the building since she was not on the daily schedule or on the CNA assignment sheet. E5 stated that E24 reported for work unscheduled, and the facility was going to send her home, but then decided to have her stay to assist with residents on the south side (rooms 500 and 600). 2/5/19 - An Incident Report Follow Up reported to the State Agency stated, "This is a substantiated case. Aide (E24) in question to be terminated. Resident has no recollection. He/She feels safe at the building. Review of the abuse policy has been done with the clinical staff and the management team. Review questions will be randomly asked of the staff to verify that they have an understanding of the policy. Police investigation remains open. Building investigation is closed." 2/17/19 - A disciplinary action form for E24 (CNA) for a violation on 1/31/19 at 7:45 PM, stated, "On 1/31/19 it was reported that you struck a resident. An investigation was done and this claim was substantiated. This is a violation of the company abuse policy. You are terminated from employment." The form was presented to the employee on 2/7/19 in the presence of E2 (acting DON), E19 (LPN), and E3 (Risk Manager). It was signed on 2/7/19 by E2 and E3 with a notation that E24 refused to sign. Findings were reviewed during an interview with E2 (DON) and E3 (Risk Manager) on 2/7/19 at 8:51 AM.	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 14 Despite E24 having had abuse training in October 2018, the facility failed to ensure that R15 was free from verbal and physical abuse, as evidenced by inappropriate responses to R15's behavior that resulted in an incident when R15 was taunted to the point of anger that caused aggression, resulting in a physical confrontation in which E24 pushed R15. Findings were reviewed during the exit conference on 2/7/19 at approximately 3:45 PM with E1 (NHA), E2 (acting DON), E3 (Risk Manager), and E20 (Regional Director of Clinical Services).	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on review of the clinical record and review of facility documentation, it was determined that for one (R15) out of 15 sampled residents, the facility failed to implement the facility's written policy and procedure for resident abuse, specifically to document the incident in the nurses' notes. Findings include: Cross refer F600	F 607	Preparation and submission of this Plan of Correction does not constitute an admission of or agreement with, it is required by State and Federal law. It is executed and implemented as a means to continuously improve the quality of care to comply with State and Federal requirements. 1) Late entry nurses note completed on	3/6/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 15 The facility policy entitled Delaware Resident Abuse Policy, last revised on 6/21/18, stated, "Documentation in the nurses' notes should include the results of the resident's ROM, body assessment, vital signs, the notification of the physician and the responsible party, and treatment provided." Review of R15's clinical record revealed: Review of nurses' progress notes for R15 revealed no evidence of a note relating to the alleged abuse on 1/31/19. Review of R15's facility incident report stated that R15's responsible party, his/her daughter, was notified of the incident on 1/31/19 at 9:30 PM. Findings were confirmed during an interview with E2 (DON) on 2/7/19 at 8:51 AM. The facility failed to implement their Delaware Resident Abuse Policy by failing to document the resident's ROM, body assessment, vital signs, notification of physician and responsible party, and treatment provided in the nurses' notes. Findings were reviewed during the exit conference on 2/7/19 at approximately 3:45 PM with E1 (NHA), E2 (acting DON), E3 (Risk Manager), and E20 (Regional Director of Clinical Services).	F 607	resident R-15 to include ROM, body assessment vital signs, notification of RP, MD and treatment provided. 2) All residents having a reported allegation of abuse have the potential to be affected. Abuse allegations from date of survey exit were reviewed to ensure nurses notes contained documentation of ROM, body assessment vital signs, notification of RP, MD and treatment provided. If observed, a late entry was created to meet this requirement. 3) To prevent this from recurring the Director of Nursing/or delegate will educate professional staff on required documentation when a abuse allegation is made. 4) To monitor and maintain ongoing compliance NHA/designee will review each abuse allegation to ensure nurses notes include ROM, body assessment vital signs, notification of RP, MD and treatment provided. This will occur 5 times a weekly for 4 weeks until 100% compliance is achieved and then weekly for 2 months until substantial compliance is maintained. Results to be reported to QAPI committee monthly for further review and recommendations.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		3/6/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 16 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review, and review of hospital records and other facility documents as indicated, it was determined that for one (R13) out of 15 sampled residents, the facility failed to ensure that an injury of unknown origin, which had the potential of being a result of physical abuse, was reported immediately, but not later than 2 hours after the injury (facial bruising and swelling) was first observed, to the State Survey Agency. Although facility staff observed bruising and swelling to R13's face, they erroneously attributed it as resulting from a fall which occurred 5 days prior and they failed to report it to the State Agency in a	F 609	Preparation and submission of the Plan of Correction does not constitute an admission of or agreement with, it is required by State and Federal law. It is executed and implemented as a means to continuously improve the quality of care to comply with State and Federal requirements. 1) Report for R-13 was submitted on 2/4/19. 2) All residents having experienced a federally reported event have the potential to be affected. Reportable events occurring from date of survey exit were	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 17 timely manner. Findings include: Review of R13's clinical record revealed the following: 10/26/17 - R13 was admitted to the facility with diagnoses that included severe dementia. 12/31/18 - The Significant Change MDS assessment stated that R13's daily decision making skills were severely impaired and he/she required extensive assist of two staff for bed mobility and transfer. 1/27/19 1:08 PM - A facility SBAR Communication Form, completed by E21 (LPN), stated that E22 (CNA) observed R13 walking in the TV lounge as she (E22) came out of the dining room. R13 fell onto the wheelchair weight scale before E22 was able to get to him/her. E21 wrote that on initial assessment there was no hematoma, although R13 hit his/her head, but there was a bruise noted to his/her left knee. R13 had no complaints of pain. 1/27/19 2:35 PM (Sunday) through 1/30/19 11:00 PM (Wednesday) - Review of nursing progress notes revealed documentation regarding monitoring of R13 due to the fall that occurred on 1/27/19. The notes stated that neuro checks were ongoing and there was bruising to the left knee. There was no evidence of any other injuries. 2/2/19 10:00 AM - A facility SBAR Communication Form, completed by E19 (LPN), stated "...bruising and swelling to bilateral (both) eyes, face and forehead possible latent injuries of 1/27/19 fall...general edema (swelling) to face bilateral eyes swollen R (right) eye greater than L	F 609	reviewed to ensure reporting of abuse was completed with in 2 hours from time of event. No issue was identified. 3) To prevent this from recurring the Director of Nursing/or delegate will educate Risk Manager and nurse management on timely event reporting. 4) To monitor and maintain ongoing compliance NHA/Designee will review reportable events to ensure reporting of abuse was completed with in 2 hours of time of event. This will occur with each event for 4 weeks until 100% compliance than weekly for 2 months until substantial compliance is maintained. Events will be reported as necessary. Results to be reported to QAPI committee monthly for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 18 (left). Broken blood vessel to R sclera (white part of the eye)...bruise to mid forehead. RP (Responsible Party) requesting resident to be sent to ER for eval (evaluation)." 2/2/19 - R13 was admitted to the hospital for evaluation of a forehead hematoma and facial bruising and swelling. 2/2/19 - The hospital H&P stated, "...CT head negative for acute (sudden onset) hemorrhage (bleeding) although the subgaleal hematoma was visualized with bilateral periorbital (around the eyes) soft tissue swelling...does appear to have a hematoma on the right side of forehead...". 2/4/19 8:19 AM - A hospital physician's progress note stated, "...Small 3 centimeter hematoma on right side of forehead...periorbital edema which is dark red/purple...fall - per reports was one week ago but there is concern that periorbital edema is new - does not seem to be in a distribution consistent with injury from a fall and direct trauma but tracking from forehead trauma is possible and his/her CT head does show signs of externally obvious forehead trauma...". 2/5/19 - R13 was readmitted to the facility. The Interagency Nursing Communication Record stated that R13 had a R facial hematoma, 2 black eyes and an evolving bruise. 2/5/19 2:40 PM - During an interview, E19 (LPN) stated she worked the day shift on 2/2/19 and that she had last worked on Thursday 1/31/19 and R13 had no swelling or bruising. 2/5/19 3:20 PM - During an interview, E11 (LPN) stated that R13 had a bruise to his/her forehead and swelling when he saw him/her on Friday	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 19	F 609		

(2/1/19) between 5- 6 PM. E11 stated that he was told that R13 had fallen 2 days or so ago.

2/6/19 10:30 AM - During an interview, H1 (hospital Forensic Nurse Examiner) stated that the left knee had a healing abrasion, but the facial bruising was purple/red indicating it was an acute injury and not from a week ago.

2/6/19 11:25 AM - During an interview, E21 (LPN) stated that on 1/27/19 when R13 fell he/she landed on his/her left side, hitting the left side of his/her head and his/her left knee. E21 stated the only visible injury was to the left knee.

2/6/19 11:35 AM - During an interview, E22 (CNA) stated that she saw a red mark on R13's face near his/her right eye on Friday, 2/1/19. E22 stated that she informed E19 (LPN) and E3 (Risk Manager). When the surveyor asked if she was sure since E19 did not work on 2/1/19, E22 hesitated, but then stated no, she wasn't changing her story.

2/6/19 11:47 AM - During an interview, E3 (Risk Manager) stated that she first became aware of R13's bruising and swelling on Saturday (2/2/19) morning when R13's son came into the facility and informed her.

2/6/19 1:40 PM - During an interview, E23 (CNA) stated that he worked 2/1/19 on the 3-11 PM shift. E23 stated that he observed bruising on R13's face "but it was old."

The facility failed to identify that R13's facial bruising and swelling was located on the right side of his/her head instead of the left. The fall on 1/27/19 resulted in R13 falling on his/her left side with no evidence of facial injuries noted for a total

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 20 of 5 days (1/27/19 through 2/1/19). As a result, the facility failed to immediately report R13's injury of unknown origin to the State Survey Agency on 2/1/19 when it was observed by staff. R13's injury of unknown origin was not reported to the State until 2/4/19 at 4:24 PM, approximately 3 and a half days later. 2/6/19 8:10 AM - R13 was observed lying in bed alert. R13 was observed with a right scleral hemorrhage, a lump on the right side of the forehead, reddish purple bruising on the eyelids and below his/her eyes, and bruising below the right eye extending downwards along his/her cheekbone and toward the right side of his/her mouth and jaw. Findings were reviewed with E1 (NHA), E2 (acting DON), E3 (Risk Manager), and E20 (Regional Director of Clinical Services).	F 609		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 657		3/6/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 21 and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on review of clinical records and interviews, it was determined that for 3 (R5, R9, and R12) out of 6 sampled residents, the facility failed to review and revise each resident's comprehensive care plan to include recommendations from their swallow study tests and physician's orders. Findings include: 1. Review of R9's clinical record revealed: 1/8/19 - R9 had a Fiberoptic Endoscopic Evaluation of Swallowing (FEES) test, which resulted in the following recommendations: - Mechanical soft food texture; - Sit upright with all intake. Remain upright for 20-30 minutes; - Small sips via cup; and - Aspiration and reflux precautions. Review of R9's comprehensive nutrition care plan, last reviewed on 12/28/18, lacked evidence of the FEES recommendations. 2/7/19 at 1:20 PM - Findings were reviewed with E2 (interim DON). The facility failed to revise R9's nutrition care plan to include the FEES recommendations based on his/her needs.	F 657	Preparation and submission of this Plan of Correction does not constitute an admission of or agreement with, it is required by State and Federal law. It is executed and implemented as a means to continuously improve the quality of care to comply with State and Federal requirements. 1) R-5 Care plan was updated to include puree diet, choking and reflux precautions. The care plan was also updated to include alternating liquids and solids, small/more frequent meals, maintaining upright position greater than 45 minutes after eating: Medication in puree: Allow ice chips apart from meals after oral care out of bed for meals, supervise/assistance with meals. R-9 Care plan updated to include Mechanical soft food texture; sit upright with all intake. Remain upright 20-30 minutes; small sips via cup and aspiration and reflux precautions. R-12 Care plan updated to include sit upright with all intake. Remain upright for 20-30 minutes and aspiration reflux precautions. 2) Residents who have FEEs testing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 22 Findings were reviewed during the exit conference on 2/7/19 at approximately 3:45 PM with E1 (NHA), E2 (acting DON), E3 (Risk Manager), and E20 (Regional Director of Clinical Services). 2. Review of R12's clinical record revealed: 1/8/19 - R12 had a FEES test, which resulted in the following recommendations: - Sit upright with all intake. Remain upright for 20-30 minutes; and - Aspiration and reflux precautions. Review of R9's comprehensive nutrition care plan in his/her clinical record, last reviewed on 2/4/19, lacked evidence of the 1/8/19 FEES recommendations. 2/7/19 at 1:20 PM - Findings were reviewed with E2 (interim DON). The facility failed to review R9's nutrition care plan to include the FEES recommendations based on his/her needs. Findings were reviewed during the exit conference on 2/7/19 at approximately 3:45 PM with E1 (NHA), E2 (acting DON), E3 (Risk Manager), and E20 (Regional Director of Clinical Services). 3. Review of R5's clinical record revealed the following: 11/21/18 - R5 was readmitted to the facility post hospitalization. Discharge diagnoses from the hospital included aspiration pneumonia in both lower lobes of the lungs. 11/21/18 - R5's readmission orders included:	F 657	completed have the potential to be affected. Care plans were reviewed for recommendations and corrections made when indicated. 3) To prevent this from reoccurring the Director of Nursing and/or delegate educated professional nurses on updating care plans with Fee's recommendations when received. 4) To monitor and maintain ongoing compliance DON/Designee will review residents with FEEs recommendations will be reviewed 5 times weekly for 4 weeks until 100% compliance is achieved and then 1 time weekly for 2 months until substantial compliance is maintained. Corrections will be made when necessary. Results will be reported to QAPI committee monthly for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 23 Aspiration Precautions; Dysphagia I (Pureed) diet; Nectar thickened liquids; Assist with meals; Out of bed for meals. 12/3/18 - A care plan was initiated for R5's swallowing disorder related to dysphagia. Interventions included diet as ordered per MD, medications are to be given crushed or given whole with applesauce/pudding, monitor for signs/symptoms of dehydration, ST per orders, and Dysphagia 1 diet with nectar thick liquids. The care plan failed to include the interventions for R5 to be out of bed for meals and to be assisted with meals. 12/13/18 11:05 PM - R5 was sent to the ER post fall. R5 was subsequently admitted to the hospital with a diagnosis of pneumonia, with concern of aspiration. 12/18/18 - R5 was readmitted to the facility. 12/18/18 - R5's readmission orders included: Aspiration Precautions; Dysphagia I (Pureed) diet; Nectar thickened liquids; Assist with meals; Out of bed for meals. The facility again failed to revise the swallowing disorder care plan to reflect that R5 was to be out of bed and assisted for meals. 1/14/19 - R5 had a Fluoroscopic Swallow Study completed at the hospital as an outpatient. Recommendations included: 1. Continue Dysphagia 1 (puree) with nectar thick liquids with supervision/assistance; 2. Choking and reflux precautions; 3. Alternate liquids and solids, small/more frequent meals, maintain upright greater than 45 minutes after eating;	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 24 4. Medications in puree; 5. Allow ice chips apart from meals after oral care. The facility failed to revise R5's care plan to include the recommendations from the swallow study. 2/7/19 at approximately 3:45 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (acting DON), E3, and E20 (Regional Director of Clinical Services).	F 657		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.	F 660		3/6/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 25 (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or	F 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 26 resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to implement an effective discharge plan that ensured the discharge needs of each resident were identified for one (R11) out of 6 sampled residents. Findings include: Review of R11's clinical record revealed the following: 12/3/18- R11 was admitted to the facility for short-term rehabilitation. 12/4/18- An order was written and signed by the physician for R11 to receive a modified barium swallow study due to signs/symptoms of aspiration of thin liquids and to assess the effectiveness of strategies to minimize his risk of aspiration. In addition, R11 was ordered to receive speech therapy 5 to 7 times per week to increase safety, improve communication competence, and minimize his/her risk of aspiration. 12/5/18- 12/30/18- Speech therapy monitored R11's swallowing and adjusted his/her diet, even upgraded it, as needed throughout his/her time at the facility, however, there was no evidence that the physician ordered swallow study was completed. 12/30/18- R11 was discharged from the facility to home.	F 660	Preparation and submission of this Plan of Correction does not constitute an admission of or agreement with, it is required by State and Federal law. It is executed and implemented as a means to continuously improve the quality of care to comply with State and Federal requirements. 1) R-11 Responsible party was notified on regarding recommendation of a swallow study. 2) All discharge residents have the potential to be affected. Residents from date of survey exit with orders for follow up swallow studies reviewed to ensure they have been communicated in the discharge plan. No issues were identified. 3) To prevent this from reoccurring the Director of Nursing and/or delegate educated social service professional nurses on completion of discharge planning/communication to include swallow study orders. 4) To monitor and maintain ongoing compliance the DON/designee will review residents with swallow study orders reviewed to ensure communication in discharge plan 1 time weekly for 4 weeks until 100% compliance is achieved then 1 time weekly for 3 months until substantial compliance is maintained. Corrections will be made as indicated. Results will be reported to QAPI committee monthly for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 27 1/31/19- During an interview at 10:00 AM, E2 (interim DON) stated that R11's swallow study was not done while he/she was in the facility because the unit clerk was unable to schedule it. At 3:53 PM, E2 (interim DON) stated there was no evidence showing that R11 or R11's representative were notified at discharge that his/her plan of care included an order for a swallow study. There was no evidence showing that R11 or R11's representative were informed to follow up as an outpatient for a swallow study. The facility failed to ensure that all discharge needs of R11 were identified, as evidenced by, the failure of the facility to implement an effective discharge plan that included notifying R11 or R11's representative of the need for a swallow study after discharge. 2/7/19 1:30 PM- Findings were reviewed with E2 (interim DON) and E3 (Risk Manager). Findings were reviewed during the exit conference on 2/7/19 at approximately 3:45 PM with E1 (NHA), E2 (acting DON), E3 (Risk Manager), and E20 (Regional Director of Clinical Services).	F 660	further review and recommendations.	
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684		3/6/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on clinical record reviews and interviews, it was determined that for 2 (R5 and R7) out of 15 sampled residents, the facility failed to ensure that each resident received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan. For R7, the facility failed to follow physician's orders with respect to her/his medications by (1a) failure to check her/his blood pressure before administering a blood pressure medication with parameters for a total of 30 days; and (1b) failure to administer a total of 16 doses of her/his Neurontin medication during the months of Nov. 2018, Dec. 2018 and Jan. 2019. For R5, the facility failed to follow physician's orders for dietary directives and failed to position R5 correctly during a meal observation. Findings include: 1a. Review of R7's clinical record revealed: 11/18 - The November 2018 Physician Order Sheet stated to give one Amlodipine-Valsartan tablet every day for high blood pressure and to hold the medication for systolic blood pressure less than 100. 11/10/18 to 11/30/18 - Review of R7's November 2018 MAR lacked evidence that her/his blood pressure was checked prior to administering her/his blood pressure medication for 21 consecutive days. 12/18 - The December 2018 Physician Order Sheet stated to give one Amlodipine-Valsartan tablet every day for high blood pressure and to hold the medication for systolic blood pressure less than 100.	F 684	Preparation and submission of this Plan of Correction does not constitute an admission of or agreement with, it is required by State and Federal law. It is executed and implemented as a means to continuously improve the quality of care to comply with State and Federal requirements. 1) R-7 was evaluated no adverse effects noted. Doctor made aware. Reviewed for lack of blood pressures (BP) per physician order. Medication occurrence report completed for missing documentation related to Neurontin. R-5 Straw and water was removed immediately when staff made aware. 2) Residents who have orders for BP parameters and/or Neurontin orders have the potential to be affected. Residents Medication Administration Record(MAR) from date of survey exit reviewed for missing BP's. Residents with Neurontin audited to ensure medication signed out, as required. If identified a medication occurrence report generated. Residents requiring nectar thicken liquids and/or no straw have the potential to be affected. Room rounds completed for proper consistency of liquids at bedside and no straws. 3) To prevent this from reoccurring the Director of Nursing and/or delegate educated on documentation medication given and recording of BP's. Professional nurses, Certified Nursing Assistance (C.NA) and activity staff educated on liquid consistency. Staff also educated on how to identify residents who require	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 29 12/1/18 to 12/9/18 - Review of R7's December 2018 MAR lacked evidence that her/his blood pressure was checked prior to administering her/his blood pressure medication for 9 consecutive days. 2/7/18 at 1:20 PM - Findings were reviewed with E2 (interim DON). The facility failed to check R7's blood pressure before administering a blood pressure medication with parameters for a total of 30 days during the months of November 2018 and December 2018. 1b. Review of R7's clinical record revealed: 11/18 - The November 2018 Physician Order Sheet stated to give one Neurontin tablet three times a day for nerve pain. 11/10/18 to 11/30/18 - Review of R7's November 2018 MAR lacked evidence that she/he received 8 doses of Neurontin (11/10/18 at 10 PM, 11/11/18 at 10 PM, 11/14/18 at 10 PM, 11/15/18 at 10 PM, 11/16/18 at 10 PM, 11/17/18 at 10 PM, 11/19/18 at 2 PM and 11/22/18 at 10 PM). 12/18 - The December 2018 Physician Order Sheet stated to give one Neurontin tablet three times a day for nerve pain. 12/18 - Review of R7's December 2018 MAR lacked evidence that she/he received 4 doses of Neurontin (12/6/18 at 12:30 PM, 12/12/18 at 6 AM and 10 PM and 12/13/18 at 10 PM). 1/19 - The January 2019 Physician Order Sheet stated to give one Neurontin tablet three times a day for nerve pain.	F 684	modified fluids or no straw via liquid consistency and "no Straw" list. 4) To monitor and maintain ongoing compliance DON/designee will review all residents with medication with BP parameters have BP's and all residents with orders for Neurontin records for completion of documentation, All residents with dysphagia who have orders for altered liquid consistency and/or "no Straw" reviewed for proper consistency including all shifts, weekends, on all hall and units and while in activities 5 times weekly for 4 weeks until 100% compliance achieved then 1 time weekly for 2 months until substantial compliance is achieved. Corrections will be made when necessary. Results will be reported to QAPI committee monthly for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 30 1/19 - Review of R7's January 2019 MAR lacked evidence that she/he received 4 doses of Neurontin (1/23/19 at 12:30 PM, 1/25/19 at 6:30 AM and 8:30 PM and 1/29/19 at 6:30 AM). 2/7/18 at 1:20 PM - Findings were reviewed with E2 (interim DON). The facility failed to administer a total of 16 doses of R7's Neurontin medication during the months of November 2018, December 2018 and January 2019. 2. Review of R5's clinical record revealed the following: 11/21/18 - R5 was readmitted to the facility post hospitalization. Discharge diagnoses from the hospital included aspiration pneumonia in both lower lobes of the lungs. 11/21/18 - R5's readmission orders included the following: - Aspiration Precautions; - Dysphagia I (Pureed) diet; - Nectar thickened liquids; - Assist with meals; - Out of bed for meals. 12/3/18 - A care plan was initiated for R5's swallowing disorder related to dysphagia. Interventions included diet as ordered per MD, medications are to be given crushed or given whole with applesauce/pudding, monitor for signs/symptoms of dehydration, ST per orders, and Dysphagia 1 diet with nectar thick liquids. The care plan failed to include the interventions for R5 to be out of bed for meals and to be assisted with meals. 12/4/18 - The CNA Kardex noted R5 was on a pureed diet with nectar thick liquids, no straws	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 31 and that he/she has a swallowing/aspiration problem. The CNA Kardex failed to note that R5 was to be out of bed and assisted for meals. 12/13/18 11:05 PM - R5 was sent to the ER post fall. R5 was subsequently admitted to the hospital with a diagnosis of pneumonia. 12/18/18 - R5 was readmitted to the facility. 12/18/18 - R5's readmission orders included: Aspiration Precautions; Dysphagia I (Pureed) diet; Nectar thickened liquids; Assist with meals; Out of bed for meals. 12/20/18 - The physician's readmission H&P stated, "...he/she fell again and was rehospitalized, this time was found to have pneumonia, concern for aspiration." The swallowing disorder care plan and CNA Kardex were again not revised to reflect that R5 was to be out of bed and assisted for meals. 1/14/19 - R5 had a Fluoroscopic Swallow Study completed at the hospital as an outpatient. Recommendations included: 1. Continue Dysphagia 1 (puree) with nectar thick liquids with supervision/assistance; 2. Choking and reflux precautions; 3. Alternate liquids and solids, small/more frequent meals, maintain upright greater than 45 minutes after eating; 4. Medications in puree; 5. Allow ice chips apart from meals after oral care. The following observations were made of R5: 1/30/19 12:47 PM - R5 was lying in bed with the	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 32 head of the bed at a 45 degree angle, leaning over to his/her left side. R5 was slowly feeding himself/herself when staff brought in a nectar thick beverage. The facility failed to ensure that R5 was out of bed for the meal in an upright position. 1/31/19 11:20 AM - R5 was observed lying in bed, leaning over to his/her left side with the head of the bed at 45 degrees. A large Styrofoam cup, dated 1/31/19 7-3 shift, was on R5's over bed tray table within his/her reach. The cup contained approximately 4-6 ounces of regular water and had a straw in it. E6 (RD) was interviewed and confirmed R5 was on a pureed diet with nectar thick liquids. E6 confirmed the resident was on aspiration precautions and should not have regular water with a straw at the bedside. E6 removed the cup and straw from the room. 1/31/19 1:00 PM - R5 was observed lying in bed with the head of the bed at 45 degrees, leaning over to his/her left side. R5's lunch was on the tray table in front of him/her, but he/she had not eaten. R5 had drunk approximately 6 ounces of nectar thick juice. R5's meal ticket stated "No Straws." A Styrofoam cup containing melting ice chips and a straw was on the tray table within R5's reach. E3 (Risk Manager) was informed and she removed the cup and straw from the room. The facility failed to ensure that R5, who was on aspiration precautions, received care and services to minimize the risk for aspiration. 2/7/19 at approximately 3:45 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (acting DON), E3 (Risk Manager), and E20 (Regional Director of Clinical Services).	F 684		
F 689	Free of Accident Hazards/Supervision/Devices	F 689		3/6/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689 SS=G	Continued From page 33 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, interview, review of hospital records and other facility documents as indicated, it was determined that the facility failed to ensure that the resident environment remained as free of accident hazards as possible and that each resident received adequate supervision to prevent accidents for two (R5 and R6) out of 15 sampled residents. For R5, the facility failed to ensure adequate supervision by failing to comprehensively assess R5's continence status and failing to develop a toileting plan. Despite knowing that R5 did not utilize the call bell, continued to self transfer to toilet, and had poor safety awareness due to dementia, there was no evidence that safety checks were implemented for this resident in an attempt to minimize falls and injury. This deficient practice resulted in harm to R5 when he/she transferred independently and sustained a pubic ramus (pelvic) fracture. For R6 , the facility failed to provide adequate supervision on the night of R6's fall (10/14/18) due to decreased staff availability to supervise. R6 sustained harm when he/she fell walking to the bathroom independently without supervision, because no staff members were available to answer his/her call bell, and he/she acquired a subdural hematoma. Findings include:	F 689	Preparation and submission of this Plan of Correction does not constitute an admission of or agreement with, it is required by State and Federal law. It is executed and implemented as a means to continuously improve the quality of care to comply with State and Federal requirements. 1) R-5 and R-6 IDT reviewed resident's records to ensure proper interventions are in place for falls. Interventions for R5 and R6 were appropriate on review. 2) All Residents with one or more falls have the potential to be affected. Resident records from date of survey exit reviewed by IDT for effective interventions. Plan of care updated where indicated. A call bell response audit was completed to ensure timely response. If indicated, the residents needs were immediately met by the reviewer. Immediate education was then provided by staff as required. 3) To prevent this from reoccurring the Director of Nursing and/or delegate educated professional nurses on how to identify effective fall interventions and implementation of based on diagnosis and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 34 The facility's policy titled "Fall Prevention & Management," dated April 2010, stated "...The facility will review each resident fall when they occur by following these steps: 1) Assess the resident for any injury and provide immediate treatment when necessary...2) Establish new interventions and place on the fall care plan...3) Communicate the new intervention for the resident to the staff. 4) Implement safety checks if resident is at very high risk for another fall...7) Chart all information relative to the fall and all notifications in the medical record. 8) Complete a new Fall Risk Assessment with each fall...". 1. Review of R5's medical record revealed the following: 1/10/15 - R5 was admitted to the facility with diagnoses that included dementia, difficulty walking, a history of falls and overactive bladder. 12/15 - A care plan was initiated for risk of falls or fall related injury due to a history of falls, multiple risk factors including medical, musculoskeletal, cognitive and sensory, and medications. Interventions included: report falls to physician and responsible party; incontinence or toileting plan; educate/remind resident to request assistance prior to ambulation; remind resident and reinforce safety awareness; appropriate footwear; referral for therapy screen as needed; low bed; call light within reach. 3/17/17 - R5 had a physician's order to receive the water pill Bumetanide 2 mg tablet twice daily. 3/27/18 (date reviewed & updated) - The Maintenance ADL & Safety Care Plan & Communication Tool (CNA Kardex) stated R5 was an assist of one to two staff for transfers.	F 689	cognitive status. All staff educated on promptly answering call bells to meet the residents needs. 4) To monitor and maintain ongoing compliance DON/Designee will review all falls for fall interventions based on diagnosis and cognitive status and implementation of interventions 1 time a week for 3 weeks until 100% compliance is achieved, then 1 time weekly for 2 months until substantial compliance is maintained. 5 Call light response time monitored in real time all shift, all halls and weekends. 3 times a week times 4 weeks until 100% compliance is achieved and then weekly times 2 months until substantial compliance is maintained. Corrections will be made when necessary. Results will be reported to QAPI committee monthly for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 35 The Kardex also stated R5 was an assist of one for toileting per request, he/she wore a brief and was frequently incontinent of bladder. 6/15/18 (Review date)- R5 had a care plan for refuses or resists care and not asking for assistance with ADLs, transfers and reaching. Interventions included: make physician aware of refusal, if refusing or resisting try again later, safety measures as ordered, and educate/ remind resident and/or responsible party of the risks. 7/9/18 - A quarterly MDS assessment stated R5's daily decision making skills were severely impaired, he/she required extensive assist of one staff for transfers and toilet use, and did not walk in his/her room or the corridor. The MDS stated R5's balance while moving from a seated to standing position, walking, and transfer between bed and chair or wheelchair was not steady, but able to stabilize without staff assistance. The MDS also stated that R5 was frequently incontinent of bladder (7 or more episodes of urinary incontinence, but at least one episode of continent voiding during the seven day assessment review time period) and that a trial of a toileting program had not been attempted. 7/13/18 7:00 AM - An Event Report stated R5 was found on the floor next to his/her bed wrapped in his/her bedding. There were no injuries noted. Neuro checks were initiated and a therapy screen was requested. R5 was found to have a urinary tract infection at this time. There was no evidence that a fall risk assessment was completed post fall. 7/13/18 - Both the fall care plan and CNA Kardex were noted as reviewed with no changes.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 36 7/14/18 12:30 AM - An Event Report stated R5 had an unwitnessed fall. The facility investigation revealed that R5 was found sitting on the floor on the left side of his/her bed. R5 stated that he/she had gone to the bathroom and fell on the way back. There was no evidence that a fall risk assessment was completed post fall and there were no new interventions added to R5's fall care plan. 8/21/18 7:25 AM - A facility Event Analysis Worksheet stated that R5 was found on the floor with no injuries. R5 stated that he/she slid to the floor while trying to transfer to the wheelchair. The worksheet stated the floor was wet and that the "Resident needed to be toileted." There was no evidence that the facility assessed R5's continence status at this time to develop a toileting plan in an attempt to minimize further falls. Additionally, there was no evidence that the facility completed a fall risk assessment post fall and no evidence that new interventions were added to the care plan. Additionally, despite R5's known history of falls, known history of self transfer and not utilizing the call bell, the facility did not implement safety checks according to the facility policy for fall prevention and management. 8/22/18 - An OT Screening Form stated that R5 exhibited problems with muscle weakness of arms/legs and transferring to and from the toilet. Under the comments section was written, "Patient has had decreased strength and activity tolerance along with decreased safety awareness for all txfers (transfers) and ADLs making him/her an increased risk for falls." 9/12/18 - The OT Therapist Progress & Discharge Summary stated that services originated on 8/23/18. The end of care summary	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 37	F 689		

on 9/12/18 stated that the goal was met for self care toileting and "the patient performs all toileting tasks with supervision to contact guard assist (contact with patient due to unsteadiness). The summary also stated that R5 transfers to/from toilet/commode with supervision (needs verbal cueing but no physical assist).

10/1/18 - An annual MDS assessment stated that R5's daily decision making skills were severely impaired and extensive assistance of one staff was required for transfers and toilet use. The MDS stated that R5's balance while moving from a seated to a standing position, walking, and transfer between bed and chair or wheelchair was not steady, and R5 was only able to stabilize with staff assistance. The MDS assessment also stated that R5 was occasionally incontinent of bladder (less than 7 episodes of bladder incontinence during the seven day assessment review time period) and that a trial of a toileting program was not attempted. The CAA Summary portion of the MDS triggered falls as a potential problem area for R5.

10/1/18 - A care plan was initiated for falls characterized by a history of falls/injury related to gait/balance problems, and impaired cognition. Interventions included: assist of 1 with all transfers; assist with mobility as needed; bed in lowest position; non skid foot wear when out of bed; fall risk assessments per routine and prn; provide assistance with toileting; reinforce need to call for assistance; and therapy to screen and treat as necessary.

10/2/18 - A care plan was initiated for bladder incontinence related to impaired mobility and an overactive bladder. Interventions included: resident uses disposable briefs, change

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 38 frequently and prn; and Voiding Routine: the resident likes to be toileted upon rising in the AM, before meals and at bedtime, uses a bed pan while in bed. 10/3/18 - The CNA Kardex continued to state, "Assist of one to toilet per request" and stated R5 was a stand by assist (SBA) for ADLs and transfers. There was no evidence that a toileting plan, based on a comprehensive continence assessment, was developed for R5. 11/15/18 9:30 PM - An Incident/Accident Report/Investigation stated R5 was found on the floor in his/her room on his/her left side with complaints of pain to the left knee and severe pain to the lower back. The investigation report stated the floor was dry and erroneously stated that R5 did not have any falls in the last 31-180 days. R5 had on a dry pull up but it was down around his/her knees and the resident needed to toilet. It further stated that R5 required assistance with ADLs, but would not ask. The investigation summary stated, "Resident fell...Resident was attempting to get to toilet, briefs were around knee (sic). Due to the resident's dementia he/she still feels that he/she can be independent...He/She requires additional assistance. Resident has no toileting plan in place. Resident now requires assistance with ADLs." The report stated that R5 was sent to the ER for evaluation. 11/15/18 - R5 was hospitalized post ER evaluation. Review of the hospital record revealed R5 sustained a pubic ramus (pelvic) fracture from the fall. 11/21/18 - R5 was re-admitted to the facility post hospitalization.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 39 11/21/18 - The nursing admission/readmission evaluation was completed. Section 2 of the evaluation included a fall evaluation which only consisted of 2 questions including the reason for the assessment and if there was a history of falls. The evaluation did not identify the severity of R5's risk for falls. There were no other fall risk assessments found in the medical record going back to 7/1/18. 11/21/18 to 11/24/18 - Upon R5's re-admission, an Evaluation for Continence and Retraining/Scheduled Toileting was started. The evaluation stated that a diary was to be kept for 72 hours and the resident was to be checked every hour with specific codes used to record findings. Review of the diary revealed that only seven (7) entries were made for the entire 72 hour time period. The facility failed to accurately complete the bladder evaluation. 12/4/18 - The CNA Kardex continued to state that R5 required "assist of one to toilet per request." The facility failed to ensure adequate supervision of R5 by failing to comprehensively assess R5's continence status and failing to develop an individualized toileting plan. Despite knowing that R5 did not utilize the call bell, continued to self transfer to toilet, and had poor safety awareness due to dementia, there was no evidence that safety checks were implemented for this resident as per facility policy for fall prevention and management, in an attempt to minimize falls and injury from falls. This deficient practice resulted in harm to R5. Findings were discussed with E1 (NHA) on 2/6/19 at approximately 5:30 PM.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 40 On 2/7/19 at approximately 9:30 AM, during an interview with E2 (acting DON) and E3 (Risk Manager), E2 stated that R5 "failed" the continence evaluation and confirmed the facility was lacking thorough documentation. It was pointed out to E2 and E3 that the continence assessment (11/21/18 - 11/24/18) was not completed. E3 stated that other things were reviewed, such as CNA documentation. The surveyor requested a copy of the CNA documentation, however nothing was provided. 2/7/19 at approximately 3:45 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (acting DON), E3 (Risk Manager), and E20 (Regional Director of Clinical Services). 2. Review of R6's clinical record and facility documents revealed: 2/13/18 - R6 was admitted to the facility with diagnoses that included difficulty in walking. 2/13/18 - A care plan was developed for R6, which included one that stated R6 was at risk for falls and another that stated R6 had an ADL self-care deficit. Interventions included that R6 required the assistance of one staff member during transfers. 8/13/18 - A quarterly MDS assessment stated that R6 was cognitively intact and required extensive assistance of one staff member for transfers and toileting. In addition, it was documented that R6 did not walk in his/her room or the corridor during the 7 day look back period. 10/13/18-10/14/18 - Review of the staffing on the night shift (11:00 PM-7:00 AM) on 10/13/18 to	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 41 10/14/18 revealed there were two nurses and three CNAs in the 100, 200,and 300 halls. At 6:00 AM, it was documented that one CNA went home, leaving two CNAs and two nurses for the three halls. 10/14/18 6:40 AM - The facility's Incident/Accident Report, completed by E11 (LPN), stated that R6 had an unwitnessed fall where she "was found on the floor next to the bathroom door...on (sic) a supine position ...Resident was noted with a hematoma to posterior of her head." It was documented in the report that R6 called for help and his/her call bell was within reach. The report also noted that the physician was notified at 8:00 AM, which was an hour and 20 minutes after R6 fell. 10/14/18 5:25 PM - An incident report was submitted to the State that stated R6 got out of bed and fell trying to get to the bathroom on 10/14/18 at 6:40 AM. R6 had normal neuro checks and a raised area on the base of his/her skull. R6 was sent to the hospital per NP orders. The hospital was called and stated that R6 was being admitted with a subdural hematoma. 10/14/18 - The CNA assigned to R6 on night shift documented in his statement that when R6 fell he was in another room providing care. 10/14/18 - Review of the facility's Root Cause Analysis of R6's fall revealed that on the morning of her fall R6's call light was activated and R6's assigned CNA was on another hall, providing care to a resident. The other CNA was in the 200 hall and the two nurses were in the 100 and 200 hall. The third CNA was noted to have already left the building when R6 fell, therefore there were no staff members in the 300 hall where R6 resided.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 42 The root cause of the fall was determined to be that R6 had an episode of diarrhea, did not want to soil his/her bed, R6 pushed his/her call bell, but staff response was not fast enough due to staff caring for other residents. 10/18/18 - A follow up to the 10/14/18 incident was submitted to the State and documented that R6 had a CT scan at the hospital showing at 2 mm subdural hematoma. A repeat CT scan showed no change in size and R6 returned to the facility on 10/15/18. The root cause was identified as R6 did not want to soil his/her bed and staff response to his/her call bell was slow. Staff were to be educated on answering call bells. 2/6/19 1:25 PM - During an interview R6 stated that on 10/14/18 he/she rang his/her call bell because his/her stomach hurt and he/she needed to get to the bathroom. R6 stated that his/her roommate even rang his/her call bell because it was "taking so long." R6 stated that he/she waited at least 10 minutes for someone to answer his/her call bell. When nobody came to the room R6 stated that he/she could not wait any longer, so he/she got up to go to the bathroom and ended up falling. 2/7/19 1:30 PM - Findings were reviewed with E2 (interim DON) and E3 (Risk Manager). The facility failed to ensure that R6's call bell was answered timely in order to prevent an accident, as evidenced by a fall on 10/14/18 at 6:40 AM. R6 sustained harm when he/she fell walking to the bathroom independently, because no staff members were available to answer his/her call bell, and she acquired a subdural hematoma.	F 689		
F 695	Respiratory/Tracheostomy Care and Suctioning	F 695		3/6/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695 SS=D	Continued From page 43 CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and interview, it was determined that for one (R16) out of 1 sampled resident, the facility failed to ensure that a resident who needs respiratory care, was provided such care, consistent with the plan of care. Findings include: Review of R16's clinical record revealed: 3/2/17 - A physician's order stated to change R16's oxygen humidifier bottle every Tuesday on the 11-7 shift. 9/10/18 - A physician's order stated to administer R16's continuous oxygen by nasal cannula using an oxygen concentrator device. 2/4/19 at 1:08 PM - An observation by the surveyor revealed that R16 had dried blood around her nostrils where her/his nasal cannula was placed providing her/him with continuous oxygen from an oxygen concentrator. The nasal cannula tubing was connected directly to the oxygen concentrator. The surveyor confirmed the finding with R16's nurse, E10 (RN), that the humidified bottle was absent and R16 had a physician's order for humidified oxygen.	F 695	Preparation and submission of this Plan of Correction does not constitute an admission of or agreement with, it is required by State and Federal law. It is executed and implemented as a means to continuously improve the quality of care to comply with State and Federal requirements. 1) R-16 humidifier bottle applied to oxygen when staff made aware. 2) All residents with orders for humidified oxygen have the potential to be affected. An audit of residents currently receiving humidified oxygen was completed to ensure correct set up and usage. Corrections made when indicated. 3) To prevent this from reoccurring the Director of Nursing and/or delegate educated professional nurses on following physician orders related to humidified oxygen. 4) To monitor and maintain ongoing compliance DON/designee will observe/audit all residents with orders for humidified oxygen to ensure proper set up and usage 3 times weekly times 4 weeks until 100% compliance is achieved, then 1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 44 2/7/19 at 1:20 PM - Finding was reviewed with E2 (interim DON). The facility failed to ensure that R16 was provided with respiratory care consistent with her/his plan of care.	F 695	time weekly for 2 months until substantial compliance in maintained. Results will be reported to QAPI committee monthly for further review and recommendations.	
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R6) out of 15 sampled residents, the facility failed to ensure sufficient	F 725	Preparation and submission of this Plan of Correction does not constitute an admission of or agreement with, it is	3/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 45 staffing levels to meet the residents needs in a manner that promoted each resident's rights, physical, mental, and psychosocial well-being. Findings include: Cross refer to F689 Review of R6's clinical record revealed the following: 8/13/18 - A quarterly MDS assessment stated that R6 was cognitively intact and required extensive assistance of one staff member for transfers and toileting. In addition, it was documented that R6 did not walk in his/her room or the corridor during the 7 day look back period. 10/13/18-10/14/18- Review of the staffing on the night shift (11:00 PM-7:00 AM) on 10/13/18 to 10/14/18 revealed there were two nurses and three CNAs in the 100, 200, and 300 halls. At 6:00 AM, it was documented that one CNA went home, leaving two CNAs and two nurses for the three halls. 10/14/18 5:25 PM- An incident report was submitted to the state which indicated that R6 got out of bed and fell trying to get to the bathroom on 10/14/18 at 6:40 AM. 10/14/18- Review of the facility's Root Cause Analysis on R6's fall revealed that on the morning of his/her fall R6's call light was activated and R6's assigned CNA was on another hall, providing care to a resident. The second CNA was in the 200 hall and the two nurses were in the 100 and 200 hall. The third CNA was noted to have already left the building when R6 fell, therefore, there were no staff members in the 300 hall where R6 resided. The root cause of the fall	F 725	required by State and Federal law. It is executed and implemented as a means to continuously improve the quality of care to comply with State and Federal requirements. 1) Resident R-6 was sent to the hospital for evaluation. 2) All residents have the potential to be affected. Staffing pattern audited from date of survey exit to ensure that a CNA or nurse was available to monitor CNA assignment if she/he would need to leave during assigned shift. If necessary support staff will be assigned to cover hallway and assist with answering call lights while waiting for certified/license staff to arrive at facility. 3) To prevent this from reoccurring Nursing Home Administrator (NHA) and/or delegate educated all staff on covering CNA assignments as necessary to assist answering call lights until certified/license staff has arrived at facility and have been relieved by management. 4) To monitor and maintain ongoing compliance DON/ delegate will monitor staffing daily to ensure a CNA or nurse is available to monitor CNA assignment if he/ she would need to leave during assigned shift times 4 weeks until 100% compliance is achieved, then 1 time weekly for 2 months until substantial compliance is maintained. If necessary support staff will be assigned to cover hallway and assist with answering call lights while waiting for certified/ license staff to arrive at facility times Results will be reported to QAPI committee monthly for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 46 was determined to be that R6 had an episode of diarrhea, and did not want to soil his/her bed, R6 pushed his/her call bell, but staff response was not fast enough due to staff caring for other residents. 2/6/19 1:25 PM - During an interview R6 stated that on 10/14/18 he/she rang his/her call bell because his/her stomach hurt and he/she needed to get to the bathroom. R6 stated that his/her roommate even rang his/her call bell because it was "taking so long." R6 stated that he/she waited at least 10 minutes for someone to answer his/her call bell. When nobody came to the room R6 stated that he/she could not wait any longer, so he/she got up to go to the bathroom and ended up falling. The facility failed to ensure sufficient staffing levels to meet R6's needs, as evidenced by staff not being available in the 300 hallway, where R6 resided, to answer his/her call bell when he/she needed assistance to the bathroom on the morning of 10/14/18. This resulted in R6 falling at 6:40 AM while trying to independently ambulate to the bathroom. 2/7/19 1:30 PM- Findings were reviewed with E2 (interim DON) and E3 (Risk Manager).	F 725		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on interview, review of the clinical record,	F 744	Preparation and submission of this Plan	3/27/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 744	Continued From page 47 and review of other facility documentation, it was determined that for one (R15) out of 15 sampled residents, the facility failed to ensure that residents diagnosed with dementia received the appropriate treatment and services to attain or maintain their highest practicable physical, mental and psychosocial well-being. For R15, a resident with dementia, the facility failed to implement his/her care-planned intervention for, 'do not corner if agitated, provide space, remain calm, speak softly'. Findings include: Cross refer F600 Review of R15's clinical record revealed: R15 was admitted to the facility on 3/28/15 with diagnoses that included Alzheimer's dementia, vascular dementia, and delusional disorder. The facility developed a care plan in December 2015 for the problem that R15 had the potential/showed aggression to staff when agitated. Interventions included for staff to not corner if agitated, to provide space, to remain calm, and to speak softly. Multiple incident statements from an event on 1/31/19 stated the following: R15 was asking about his/her children, thought his/her children were missing, and was calling staff names; E15 (CNA) was going back and forth with R15 and R15 became more agitated and upset; E15 stuck her tongue out at R15, jumped toward R15, and refused to leave the area when directed to do so by the nurse and other staff. On 2/5/19 at 1:40 PM, during an interview, E12 (CNA) stated that on 1/31/19, R15 asked about	F 744	of Correction does not constitute an admission of or agreement with, it is required by State and Federal law. It is executed and implemented as a means to continuously improve the quality of care to comply with State and Federal requirements. 1) R-15 care plan interventions reviewed and updated by the IDT. Interventions communicated to the frontline care givers. Kardex updated. 2) All residents with a diagnosis of dementia has the potential to be affected. All care plans audited to ensure effective and personalized non-pharmacologic behavior de-escalation interventions are in place. Where required the plan of care was updated. 3) To prevent this from reoccurring the Director of Nursing and/or delegate educated professional nurses and social service on how to recognize and develop interventions that may assist in deescalating aggressive behaviors. C.NA and direct care givers educated on deescalating aggressive behaviors and on the use of the Care Kardex. 4) To monitor and maintain ongoing compliance DON/Designee to review 5 residents with dementia care plan and Care Kardex for interventions and implementation 1 time weekly until 100% compliance is achieved the monthly time 3 months to maintain substantial compliance. Corrections will be made when necessary. Results will be reported to QAPI committee monthly for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 744	Continued From page 48	F 744		

his/her children every day. E12 (CNA) stated that R15 was asking about his/her children and E15 (CNA) was taunting the resident about his/her children. E12 (CNA) stated as R15 was going towards his/her room, he/she stood up from his/her wheelchair and hit E15 (CNA) in the arm and face. E12 (CNA) stated that she took R15 to his/her room and calmed him/her down.

On 2/5/19 at 1:50 PM, during an interview, E13 (CNA) stated that on 1/31/19, R15 was asking about his/her children. E13 (CNA) stated that E15 (CNA) stuck her tongue out at R15 and jumped toward the resident, causing R15 to become more agitated. E13 (CNA) stated that she asked E15 (CNA) to stop and to leave the area.

On 2/5/5/19 at 4:10 PM, during an interveiw, E14 (RN) stated that on 1/31/19 she was administering medication in the 500 hallway and she heard R15 calling the staff names. E14 (RN) stated that she went to the nurses' station located at the intersection of the 500 and 600 hallways and told E15 (CNA) to leave the area. E14 stated that E15 (CNA) did not leave the area, and as R15 was wheeling himself/herself past the desk, R15 stood up and hit E15 (CNA).

The facility failed to implement R15's care-planned intervention to not corner if agitated, to provide space, to remain calm, and to speak softly, which resulted in R15 reacting aggressively toward staff.

Findings were reviewed with E2 (DON) and E3 (Risk Manager) on 2/7/19 at 8:51 AM.

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: New Castle Health

DATE SURVEY COMPLETED: February 7, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced complaint and state licensure survey was conducted at this facility from January 30, 2019 to February 7, 2019. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 94. The survey sample totaled 15.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey		

Provider's Signature _____ Title Administrator Date 3/1/19

NAME OF FACILITY: New Castle Health

DATE SURVEY COMPLETED: February 7, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	completed February 7, 2019: F550, F580, F600, F607, F609, F657, F660, F684, F689, F695, F725, and F744. Abbreviations/definitions used in this report are as follows: DON – Director of Nursing; eMAR – electronic Medication Administration Record; NHA – Nursing Home Administrator; NP – Nurse Practitioner.	Preparation and submission of this Plan of Correction does not constitute an admission of or agreement with, it is required by State and Federal law. It is executed and implemented as a means to continuously improve the quality of care to comply with State and Federal requirements. 6.2.6 1) R-12 History and Physical (12/18/18) was signed by physician on 2/19/19. Progress note 12/20/18 was signed Nurse Practitioner on 1/22/19 R-5 History and Physical dated 12/20/28 was also signed on 2/19/19 2) All residents in the centers records has the potential to be affected. Review of resident's records Completed by medical records for signed and dated History and Physicals and progress noted from date of survey exit. Corrections made when indicated. 3) To prevent this from reoccurring the Medical Records Coordinator educated Medical Director and extenders on signing and dating history and physicals and progress notes at time of service.	3/6/19
3201.6.0 6.2 6.2.6	**Services To Residents** **Medical Services** **A progress note shall be written and signed by the physician or designee (an advanced practice nurse or physician's assistant) after examining the resident at each visit.** This requirement is not met as evidenced by: Based on clinical record review and interview, it was determined that for 2 (R12 and R5) out of 15 sampled residents, the facility failed to ensure that progress notes were signed by the physician or designee after examining the resident at each visit. Findings include: 1. Review of R12's clinical record revealed: 12/18/18 – A typed History and Physical progress note by E4 (physician) lacked evidence of the physician's signature on the date of the visit.		

Provider's Signature _____ Title Administrator Date 3/1/19

NAME OF FACILITY: New Castle Health

DATE SURVEY COMPLETED: February 7, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	12/20/18 - A typed Progress Note with the date of service of 12/20/18 by E16 (NP) was signed and dated 1/22/19, approximately one month later. Findings were reviewed with E2 (interim DON) on 2/7/18 at 1:20 PM. The facility failed to ensure that R12's progress notes were signed by the physician or designee after examining the resident at each visit. 2. Review of R5's clinical record revealed: 12/20/18 – A typed History and Physical progress note, completed by E4 (physician) lacked evidence of the physician's signature on the date of the visit. Findings were reviewed on 2/7/19 at 3:45 PM during the exit conference with E1 (NHA), E2 (interim DON), E3 (Risk Manager) and E20 (Regional Director of Clinical Services).	4) To monitor and maintain compliance medical records clerk to review 30 medical records for signed history and physicals; and progress notes weekly times 4 weeks until 100 % compliance, then monthly times 2 month until substantial compliance is maintained. Results to be reported to QAPI committee monthly for further review and recommendation.	
6.6	**The facility shall maintain a safe, clean, and orderly environment, free from offensive odors, for the interior and exterior of the facility.** **This requirement is not met as evidenced by:** Based on observation and interview, the facility failed to maintain a safe, clean, and orderly environment, free from offensive odors, for the interior and exterior of the facility. Findings include: The following were observed on 1/31/19 from 10:00 AM to 5:00 PM during room checks: Room 104 – The bathroom floor molding was in disrepair.	6.6 1) Maintenance Director repaired room 104's bathroom floor, secured 301's TV cables, and repaired 301's Bathroom cabinet repaired. Housekeeping supervisor cleaned the privacy curtains in Rooms 507, 510 and 601. 2) Residents rooms in the center have the potential to be affected. Room rounds completed for floor molding, loose TV cables and bathroom cabinets completed. Corrective action taken when indicated. Room rounds completed for cleanliness of cubicle curtains. Corrective action taken when indicated.	3/6/19

Provider's Signature _____ Title Administrate Date 3/1/19

NAME OF FACILITY: New Castle Health

DATE SURVEY COMPLETED: February 7, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	Room 301 – The TV cables were loose and dangling off the wall creating an accident hazard. The bathroom cabinet is in disrepair. Room 507- The B bed privacy curtain was soiled. Room 510 – The A bed privacy curtain was dirty and stained. Room 601 - The A bed privacy curtain was soiled. Findings were reviewed and confirmed by E18 (facility Maintenance Director) on 2/4/19 at approximately 10:00 AM. Findings were reviewed with E1 (NHA) on 2/4/19 at approximately 3:30 PM.	3) To prevent this from reoccurring NHA/delegate educated Maintenance supervisor and housekeeping supervisor educated on completed PM's and addressing issues. NHA/Delegate educate staff on completing work orders on maintenance and housekeeping issue. 4) To monitor and maintain compliance room PM's to be completed by NHA/Maintenance Director rounding together related to floor molding, TV cable, and bathroom cabinets weekly times 4 weeks until 100% compliance then monthly times 2 months until substantial compliance is maintained. Cubicle curtain rounds to be completed weekly for cleanliness weekly times 4 weeks until 100% compliance, then monthly times 2 months until substantial compliance is maintained. Results to be reported to QAPI committee monthly for further review and recommendations. Preparation and submission of this Plan of Correction does not constitute an admission of or agreement with, it is required by State and Federal law. It is executed and implemented as a means to continuously improve the quality of care to comply with State and Federal requirements. 6.9.2.3 1) R9 Tuberculosis screening completed.	
6.9 6.9.2 6.9.2.3	**Communicable Diseases** **Specific Requirements for Tuberculosis** **The facility shall have on file the results of tuberculin testing performed on all newly placed residents.** **This requirement is not met as evidenced by:** Based on clinical record review and interview, it was determined that for 1 (R9) out of 15 sampled residents, the facility failed to have on file the results of R9's tuberculin testing. Findings include: Review of R9's clinical record revealed: 7/27/18 – R9's Tuberculosis Screening		

Provider's Signature _____ Title Administrator Date 3/1/19

NAME OF FACILITY: New Castle Health **DATE SURVEY COMPLETED: February 7, 2019**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	Record and the July 2018 eMAR stated that a second step Mantoux Skin Test was administered. 7/30/18 – Review of R9's Tuberculosis Screening Record and July 2018 eMAR revealed that the facility lacked evidence that R9's second step Mantoux Skin Test was read. 2/7/19 at 1:20 PM - Finding was reviewed with E2 (interim DON). The facility failed to have on file the results of R9's tuberculin testing.	2) Residents in the center has the potential to be affected. Resident's records from date of survey exit record reviewed for tuberculosis screening. Corrective action taken. 3) To prevent this from reoccurring Director of Nursing/delegate educated professional nursing staff on completing TB screening test and reading results. 4) To monitor and maintain compliance Director of Nursing/ designee to audit 30 resident records weekly time 4 weeks until 100% compliance is achieved, then monthly times 2 months until substantial compliance is maintained. Results to be reported to QAPI committee monthly for further review and recommendations. Preparation and submission of this Plan of Correction does not constitute an admission of or agreement with, it is required by State and Federal law. It is executed and implemented as a means to continuously improve the quality of care to comply with State and Federal requirements. 6.9.3.3 1) R2 Pneumococcal pneumonia vaccination given.	3/6/19
6.9.3	**Immunizations**		
6.9.3.2	**All facilities shall have on file evidence of vaccination against pneumococcal pneumonia for all residents older than 65 and as recommended by the Immunization Practice Advisory Committee of the Centers for Disease Control unless medically contraindicated.**		
6.9.3.3	**A resident who refuses to be vaccinated against influenza or pneumococcal pneumonia shall be informed by the facility of the health risks involved. The reason for the refusal(s) shall be documented in the resident's medical record annually.** **This requirement is not met as evidenced by:** Based on record review and interview, it was determined that the facility failed to have evidence of vaccination against pneumococcal pneumonia for one (R2) out of 15 sampled residents. Findings include:		

Provider's Signature _____ Title Administrator Date 3/1/19

NAME OF FACILITY: New Castle Health

DATE SURVEY COMPLETED: February 7, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	Review of the clinical record lacked evidence of pneumoccal pneumonia vaccination for R2. Interview with E2 (interim DON) 2/7/19 at approximately 10:00 AM confirmed there was no evidence that R2 had been offered and/or declined the vaccine.	2) Residents in the center has the potential to be affected. Resident records reviewed from date of survey exit for residents offered and or received Pneumococcal pneumonia vaccination. Corrections made when indicated. 3) To prevent this from reoccurring Director of Nursing/Delegate will educate professional nursing staff on follow thru of processes for vaccinations. 4) To monitor and maintain compliance Director of nursing/designee to review 30 resident's records weekly times 4 weeks until 100% compliance is achieved, then monthly times 2 months until substantial compliance is maintained. Results to be reported to QAPI committee monthly for further review and recommendations. Preparation and submission of this Plan of Correction does not constitute an admission of or agreement with, it is required by State and Federal law. It is executed and implemented as a means to continuously improve the quality of care to comply with State and Federal requirements.	
3201.7. 5 5. 5-2 5-202 5-202.12 5-202.12A	**Kitchen and Food Storage Areas. Facilities shall comply with the Delaware Food Code.** **Water, Plumbing and Waste** **Plumbing System** **Design, Construction, and Installation** **Handwashing Sink, Installation** **A HANDWASHING SINK shall be equipped to provide water at a temperature of at least 38oC (100oF) through a mixing valve or combination faucet.** **This requirement is not met as evidenced by:** Based on observation and interview, the facility failed to ensure that all hand washing sinks provided adequate water temperature of at least 100F to ensure the maximum surfactant effect of the soap during hand washing. Findings include: On 1/30/19 at approximately 8:45 AM, it was		

Provider's Signature _____ Title Administrator Date 3/1/19

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: New Castle Health

DATE SURVEY COMPLETED: February 7, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	observed that the water temperature for the food prep room hand washing sink to be cold. The water did not reach at least 100F until the hot water until approximately 9:15 AM while the faucet was running continuously. Finding was confirmed with E17 (food service director) on 1/30/19 at approximately 9:00 AM. Finding was reviewed with E1 (NHA) on 2/4/19 at approximately 3:30 PM.	5-202.12A 1)Mixing valve adjusted to maintain water temperature at 100 degrees. 2) Hand washing sinks in the kitchen have the potential to be affected. Random temperature audits conduct for water temperature to maintain 100 degrees. Corrective action taken when indicated. 3) To prevent this from reoccurring the Administrator/Delegate will educate maintenance staff on kitchen hand washing sink temperature of 100 degrees must be reached 4) To monitor and maintain compliance Maintenance director/ designee to do random temperature audit daily times one week, then weekly times 4 weeks around meal prep times until 100% compliance is achieved, then monthly times 2 months until substantial compliance is maintained. Results to be reported to QAPI committee monthly for further review and recommendations.	3/6/19

Provider's Signature _____ Title Administrator Date 3/1/19